STATEMENT OF

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ON

ASSISTED SUICIDE

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Thank you, Mr. Chairman, for the opportunity to testify before the House Commerce Committee's Subcommittee on Health & Environment dealing with Assisted Suicide: Legal, Medical, Ethical, and Medical Issues. I am grateful for the chance to share these views with you and your colleagues.

My name is Rabbi A. James Rudin. I am the National Interreligious Affairs Director of the American Jewish Committee. Since 1968, I have been directly involved in strengthening interreligious relations in this country and throughout the world. I was raised in Alexandria, Virginia and after receiving my college education at George Washington University and rabbinical ordination at Hebrew Union College-Jewish Institute of Religion, I served as an United States Air Force Chaplain in Japan and Korea. Prior to joining the professional staff of the American Jewish Committee, I served Reform Jewish congregations in Kansas City, Missouri and Champaign-Urbana, Illinois. I am also a co-author of Why Me? Why Anyone? (St. Martin's Press: 1986 & Jason Aronson: 1994), a book dealing with religion and bio-ethics.

I want to make clear at the outset that the American Jewish Committee has taken no position on the question of assisted suicides. However, the New York Task Force on Life and the Law on which I have served since its founding in 1985, has taken a unanimous public position in opposition to legalizing assisted suicides.

The New York State Task Force on Life and the Law was convened by then Governor Mario Cuomo and its 25 members were given the responsibility of developing specific recommendations for public policy in New York State on a host of issues arising from recent medical advances, including the determination of death, the withdrawal and withholding of life support systems, organ transplantation, the treatment of disabled new born, surrogate parenting, do not resuscitate orders, medical power of attorneys, and, of course, assisted suicides.

In addition to my full written testimony, I am also submitting a copy of the Task Force's report, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context, which was published in May, 1994.

To paraphrase the Bible, the topic of this hearing, assisted suicide, is not something "too remote...It is not in heaven...nor beyond the sea...No, it is very near to you..." Nor is it an issue that will simply take care of itself without attention, analysis, and debate. I can assure you that the question of assisted suicide has touched, does touch, or will touch everyone in this audience.

In January, 1997, the U.S. Supreme Court heard intensive debate about the issue of assisted suicides. Justice Sandra Day O'Connor said: "This is an issue every one of us faces, young and old, male and female..." And Justice Ruth Bader Ginsburg, whose mother died of cervical cancer at the age of 47, declared: "Most of us have parents and other loved ones who have been through the dying process, and we've thought about these things." Indeed. Now it is time that we begin to think seriously "about these things."

Because of the Task Force's work, New York State now has legislation on do-not-resuscitate orders, the determination of death, organ transplantation policy, health care proxies, and surrogate decision making for patients without capacity.

My Task Force experience and its extraordinary intellectual and spiritual demands have compelled me to move far beyond my previous conventional thinking on bio-ethical issues, and Task Force membership has clearly taught me that questions like assisted suicides are much too important to be left solely to physicians and to other members of the medical profession.

One of my most serious concerns is that if we laypeople are not prepared to confront the dilemmas that currently exist in our hospitals, clinics, and nursing homes, the critical bio-ethical decisions about life and death will surely be made by others. And that would be a tragedy.

I want to speak first in general terms about assisted suicide and then conclude with a focus on a Jewish response to the question. In these remarks assisted suicide refers to actions by one person to contribute to the death of another, by providing medication or a prescription or other steps. Euthanasia refers to direct measures, such as a lethal injection, by one person to end another person's life for benevolent motives. Both practices are distinct from the withdrawal and withholding of life sustaining treatment in accord with accepted ethical and medical standards.

Interestingly, New York is one of two states that does not currently permit the withdrawal and withholding of life-sustaining treatment from an adult patient who has not signed a health care proxy or provided clear and convincing evidence of treatment wishes. Euthanasia is barred in all 50 states, but neither suicide nor attempted suicide is a criminal offense in any state.

Sooner or later almost everyone of us will face this difficult dilemma: seriously ill relatives or friends, often in severe pain and depression, will desperately seek medical help to end their lives. No longer able to go on with life, patients usually request a lethal injection or an oversupply of pills to hasten death.

How should society, how should we respond to the cries and whispers of those who beg for death? At first glance, it seems our answer should be "yes." After all, shouldn't respect for individual choice and personal self-determination permit patients and doctors to engage in assisted suicides? Aren't individual rights one of the distinctive hallmarks of American society?

While calls for assisted suicides sound compassionate and reasonable, there are too many risks in making assisted suicides legal. Even if laws were carefully framed, I strongly believe assisted suicide in the United States would certainly be practiced unequally. Besides, even "ideal" or "good" cases are not sufficient for public policy, because they bear little resemblance to existing medical and socio-economic practices in the America of the 1990s.

Those at greatest risk to lose their lives would be our poor, minority group members, those without a family, the elderly, and especially those who have no access to good heath care...America's "surplus population."

And now let me say something that has angered many in the Jewish and medical community. The legalization of assisted suicides, even for so-called compassionate reasons, reminds me of the brutal excesses of the Holocaust when Nazi physicians carried out deadly experiments upon the Third Reich's "surplus population": Jews, Gypsies, political prisoners, homosexuals, mental patients, and others.

There is a "slippery slope" attached to the question of assisted suicides that must be considered. If assisted suicide became law in the United States, the traditional wall of patient protection would be seriously lowered, and suicide would become more and more commonplace. Most physicians do not have a long-standing relationship with their patients and inquire little about the complex personal factors relevant to evaluating a request for suicide assistance. This is especially true once a patient enters a hospital's critical or intensive care unit.

In the Netherlands, where assisted suicide is legal, a study has found that of nearly 3,300 deaths annually resulting from mercy killing, 1,100 deaths occurred without an explicit request from the patient. In some of those cases, physicians provided assisted suicide in response to suffering caused solely by psychiatric illness, including severe depression.

There is a bitter irony to what is happening in Holland. During the World War II German occupation of the Netherlands, fully 98% of that country's physicians refused to join a German-sponsored medical organization that was headed by a Nazi sympathizer and an anti-Semite. The Dutch doctors took down their shingles and refused to practice although they were aware that such actions could subject them to severe punishments.

Yet, reliable sources report that today many Dutch physicians are actively participating in assisted suicides and they are systematically ignoring the guidelines that were established when such procedures were made legal. In Holland the patient must voluntarily request death, the patient's suffering must be unbearable and irrevocable, and one other physician must be consulted.

Dr. Herbert Hendin who wrote a book on the 10 year Dutch experience with assisted suicide has said: "Virtually every guideline established by the Dutch to regulate euthanasia has been modified or violated with impunity." If such excesses have in fact taken place in a small, rather homogenous nation like the Netherlands, I can only speculate with fear and trembling how such guidelines would be violated in our increasingly diverse nation of over 260,000,000 residents, and in an America where quality medical health care often varies widely from state to state, even from county to county.

People who are in good health often believe they would want a legal means to end their lives if they became seriously ill. But clinical evidence and my own experiences as a rabbi in hospitals confirm the suspicion that when people face a dread disease, life becomes even more precious, and patients usually call for maximum medical efforts to continue life.

Pain and depression are frequently cited as reasons why a person seeks assisted suicide. But the truth is that until recently many medical professionals undertreated pain. If terminally ill patients receive too many pain killers, it was thought, they might become addicted to narcotics. But clinical evidence reveals that addiction and psychological dependence is rare among patients suffering intense pain.

As a rabbi who has, alas, visited far too many hospital rooms and as a Task Force member, it is clear to me that the education of health care professionals about pain relief and palliative care must be rapidly improved. Courses should be included in medical schools, nursing schools, residencies, and all forms of continuing education for the medical profession.

Today many experts believe that modern pain relief techniques, including opioids, can ease pain in all but extremely rare cases. Fortunately, the medical profession has changed its attitude toward pain management, and there is growing recognition that a patient should not and need not suffer unrelieved pain.

In addition, pain and depression cannot be objectively measured. Since both are subjective, they must never be used as justifications for assisted suicide. What is clearly needed is a more aggressive approach to the treatment of pain and depression especially among the terminally ill.

If suicidal thoughts are commonplace when patients are seriously ill, the medical profession needs to fully explore and treat the factors that cause such feelings of despair. Too often, doctors do not discuss this critical subject with their patients.

In 1994 the New York State Task Force on Life and the Law issued a lengthy report on assisted suicides and euthanasia. After an intensive 18-month study, we unanimously concluded that assisted suicide should not be made legal. Such a public policy, we declared, "would pose profound risks to many patients...and would be unwise and dangerous..."

We also noted that the U.S. Constitution does not grant "individuals a 'right' to suicide assistance..." But two recent Federal court decisions dealing with the complex and emotional subject of physician assisted suicides have raised profound issues for America.

In March, 1996, a Washington state law banning medical suicides was struck down, and a month later a similar New York State law was also struck down. While 32 states currently have legislation forbidding assisted suicides, the two court rulings have placed all such laws in legal jeopardy, and the U.S. Supreme Court is currently debating the constitutionality of the two

laws and a decision is expected sometime this June or July. Not surprisingly, I have serious problems with both federal court decisions and I hope they are reversed by the High Court.

The lower court rulings were based on the constitutional rights of individuals to make decisions about terminating their own lives. The courts also protected physicians from criminal prosecution if they assist patients in ending their lives. The New York judgment stipulated that only mentally competent patients who are terminally ill are entitled to make such momentous decisions.

The reasoning, however, leaves a host of critical questions unanswered.

Who, after all, will decide whether a person is truly competent to make life-ending decisions about oneself? Because critically ill people are often severely depressed and in acute pain, it is not hard for a family member or a physician to extract the patient's wish to end it all. But is such an irreversible, irrevocable decision made by a truly mentally competent person? And many doctors agree that their patients' desire to die often end when they are effectively treated for depression and when severe pain is eased.

And what exactly is a terminal medical condition? Is it a seriously ill person who has only 6 hours, 6 days, 6 weeks, or 6 months to live? Who can guarantee the accuracy of these precise time frames?

As health costs continue to soar, insurance companies and hospitals will increasingly seek the most cost-efficient means of treating patients. Clearly, it is more expensive to treat an individual's physical pain and mental depression than it is to assist a person to die. The financial bottom line will always prefer assisted suicides over the more costly treatments for pain and depression.

And what about those family members who are eager to receive their inheritance money as quickly as possible from an acutely ill relative? We can easily guess their views about assisted suicide.

The recent court decisions presuppose careful deliberation of assisted suicide by all interested parties: patients, physicians, hospitals or nursing homes, and families. But such ideal circumstances rarely exist in intensive care units or hospital corridors.

In the real medical world the first people who will be assisted in ending their lives will be the poor, those without family or friends, the elderly, the disabled, and uninsured patients who can not pay for their medical treatment.

There is another chilling aspect as well. Everyone knows that some physicians covertly aid their patients to die. Sometimes this is done by acts of commission like prescribing certain medications to hasten death. But often death comes through acts of omission when doctors do

not aggressively treat such problems as pneumonia and other deadly infections when they occur among seriously ill patients.

This furtive behavior has placed enormous strain upon the medical community, and no wonder many physicians are looking for a legal remedy for their ethical predicaments. While fully recognizing the torment of both physicians and patients, I am fearful that legalizing assisted suicides will permanently replace the traditional role of doctors as healer with that of potential killer.

I believe we can do far more for patients by improving pain relief and palliative care than by changing the law to make it easier to commit suicide or to obtain a lethal injection. And I am profoundly concerned that legally approved assisted suicide would also be applied to patients suffering severely, but who are not "terminally ill," those people with conditions such as cancer, AIDS, ALS (Lou Gehrig's disease) or advanced emphysema. In the real world, compassionate medical personnel, including physicians will make no distinction between such suffering patients and those who are defined as "terminally ill."

I believe the Jewish religious tradition brings some special gifts and experiences to this debate. Ours is a life-affirming religion. When Jews make the toast, L'hayim, we stress our commitment to life. According to Judaism, every life is sacred, so everything possible must be done to save even a single individual. As one Talmudic sage explains: "We should disregard one Sabbath for the sake of saving the life of a person so that a person may be able to observe many Sabbaths."

Unfortunately, I do not have the time to rehearse in careful detail the long and fruitful relationship between Judaism and medicine through the long centuries. Moses Maimonides, that religious giant of the 12th century who was both a rabbi and a physician, warns us "not to live in a city that has no doctor."

Judaism stresses the natural aspect of death and teaches we should not fear the end of our lives. And since God alone determines death, it can not be hastened in any way. Indeed, according to the tradition, an individual who performs any act that may inadvertently hasten death, such a person is regarded as a shedder of innocent blood.

It seems to me that we must choose between two basic positions. Clearly, I have already made my choice, but let me attempt to lay out the salient questions. The argument hinges on an acceptable definition of life and when it stops being meaningful. One position holds that since we are created in God's image, all human life is sacred; so extending a person's life for even a few seconds is as valid and worthwhile as extending it for decades.

The other view maintains that each medical case must be reviewed individually, that the quality of life can be defined and evaluated by a set of verifiable standards, such as: Is the patient conscious, with mental capacity and reason? I call these alternative positions the "sanctity

of life" argument and the "quality of life" argument.

Because Judaism teaches that every human life is infinitely valuable and we must make every effort to save it, the tradition emphasizes the first position. According to Jewish religious law, if we don't do everything possible to save or prolong life, we are shortening it, which is forbidden.

Because of medical advances, some Jews now advocate the second or "quality of life" position. They assert that the "sanctity of life" argument, while highly admirable, does not apply to every situation, arguing that God does not require us to extend a meaningless life of pain without realistic expectations of recovery.

But if we don't act to prolong life, aren't we really shortening it? Judaism is staunchly opposed to doing anything that even slightly hastens death. Life is a divine gift and it is God alone Who determines how and when death will come.

Rabbi Joseph Caro, a leading rabbinic authority (1488-1575), declared: "We are not permitted to close the eyes of a person who is near death, lest we cut off even a fraction of life." We are not permitted to remove a pillow or a cushion from a dying person if such an act will in any way speed up death. Nor can we withhold food, water, and necessary medicine from a patient.

According to Moses Isserles, a sixteenth century scholar from Cracow, Poland, "If a person is near death, do not even remove the cushion or pillow under his head, lest it speed up death." And Moses Maimonides opposed all "passive euthanasia" actions: "He who kills a healthy person, and he who kills a sick person who is dying anyway, even if he is almost dead, all are guilty of murder!"

The late Rabbi Moses Feinstein, one of this century's leading Orthodox Jewish authorities even approved dangerous radical surgery as a risk worth taking to prolong life. And in a fascinating section of the Talmud, one commentator asserts: "When we are in doubt about whether a patient will live or die, we must not allow idolaters to heal. But if the patient certainly will die, we may allow the idolaters to heal." It is a remarkable teaching given Judaism's strong antipathy to all forms of "non scientific" medical treatments.

However, the entire question of what today would call assisted suicide is carefully nuanced in the Jewish tradition. Rabbi Solomon Freehof, one of Reform Judaism's greatest Talmudic scholars, argues that while the Jewish tradition permits us to take risks to save lives, it does not allow us to prolong the natural process of dying. I stress the word "natural." Freehof rightly calls this area "murky and ambiguous", and admitting the inner contradiction of his position, says: "We must fight for every second of life actively, but we can be passive in the case of a terminally ill person." But we can not actively hasten death through assisted suicides.

Freehof and others highlight the enormous tension in Jewish thought between preserving life and not interfering with the natural process of dying. Judaism absolutely forbids killing by active intent. But what about passive euthanasia, such as removing a life-support system, refusing to resuscitate, or refusing to begin new medical or drug therapy on a patient? Is this morally and legally a form of assisted suicide?

Two dramatic Talmudic stories provide justification to remove such systems from seriously ill patients. But even in these stories, I do not detect any justification for providing the specific means for a patient to kill oneself.

Because Rabbi Hananiah ben Teradyon taught the Torah, a severe crime in Roman times, the Roman occupation authorities executed the rabbi by burning him at the stake. To prolong the rabbi's torture, the Romans covered him with water-filled sponges to insure that death would not come quickly.

As the fire grew hotter, Hananiah's students begged him to draw the fire into his throat, and by so doing take his own life and end his suffering. The rabbi refused to allow the fire to enter his throat to hasten his own death even though he was clearly in a "terminal" situation. However, he did permit a Roman soldier to remove the sponges from him, and soon after Hananiah died.

It is a subtle but critical point. The dying man would not allow the fire to enter his throat----an active step----but he did permit the removal of the sponges, his primitive life-support system---a passive act.

The Talmudic scholars, of course, commend the rabbi for his brave martyrdom in behalf of teaching God's word, the Torah, but surprisingly they also praise the unknown Roman soldier for removing the sponges, and both Rabbi Hananiah and the soldier are accorded honored places in the world to come. For me, this complex story teaches that you are rewarded for easing the pain of a dying person. Those with no hope of escaping death can request that the dying process be shortened, although they cannot take steps themselves to shorten their lives.

In the second story, the great Talmudic authority Rabbi Yehudah Ha Nasi, Judah the Prince, lay dying in his house, while his adoring students gathered outside to pray for his recovery. Since, according to the Jewish tradition, prayers for the sick are considered just as effective as medical treatment, the students' petitions to God provided a kind of life-support system for the patient.

Judah's agony worsened. His female attendant, acutely aware of her patient's intense suffering, in desperation took a large earthen jar to the roof of the rabbi's house and hurled it to the ground below, where it shattered into many pieces. Stunned by the noise, the students momentarily stopped their prayers, thereby withdrawing the spiritual "support system." The

Talmud recounts that in that brief period of silence, Judah the Prince died. It praises the attendant, even though her behavior hastened Judah's death.

I am willing to concede that based upon the Talmudic examples and my own real life experiences that there may indeed be a tiny number of cases in which physician assisted suicide could be ethically and medically defended on very narrow grounds. But I am also convinced that there would be many, many more cases in which assisted suicides would take place in inappropriate, unethical, and medically questionable ways.

But one thing is clear for all to see: the hospital room has become the "New Frontier" in addressing the moral and spiritual questions that are usually discussed in abstraction. Today we must be centrally involved as difficult bioethical questions increase in number and complexity, and as advances in medical technology provide us with more and more choices.

Dr. Fred Rosner, a professor at Yeshiva University's Albert Einstein School of Medicine and a leading bio-ethicist, put the issue in its most graphic terms: "When physicians recognize they have no more to offer medically, they no longer have the license to treat...There is a point where we just must learn to ease pain [and depression] better."

As a society, we can do far more to benefit patients by improving pain relief and depression than by radically changing our laws to make it easier to commit suicide. Thank you.